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2d Session
HOUSE OF REPRESENTATIVES
REPORT
104–646

ANTITRUST HEALTH CARE ADVANCEMENT ACT OF 1996

JUNE 27, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HYDE, from the Committee on the Judiciary,

submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 2925]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 2925) to modify the application of the antitrust laws to health care provider networks that provide health care services; and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE AND SUMMARY

Recent demand to lower health care costs and to improve quality of health care services has increased the popularity of physician-controlled provider networks. These network arrangements promise significant, pro-competitive benefits for consumers. But because physicians in networks collectively price their services, they are susceptible to a challenge under the antitrust laws for illegal price fixing. Physicians and other health care providers who wish to form networks, but want to do so without violating the antitrust laws, are seeking guidance as to how the law will be applied. Current law permits price fixing agreements if they are necessary to achieve the efficiencies associated with a network of competitors who are integrated in a joint venture.

The Antitrust Health Care Advancement Act of 1996 is intended to ensure that health care provider networks which bear the indicia

of a legitimately integrated joint venture will receive rule of reason consideration. Doing so will erase the rigid and artificial antitrust barrier to the formation of networks other than those described in current enforcement guidelines as "safety zones." It will remove the fear of criminal penalties, or treble civil damage awards, for those who are in good faith attempting to engage in pro-competitive ventures. It will bring competition into the managed care dominated health care delivery system, and let the marketplace determine the contours of provider networks which will satisfy the needs of the health care consumer.

The goal of this legislation is to remove artificial antitrust barriers to the formation of new types of delivery systems: to encourage the creation of new competitive entities. These partnerships will consist of persons with shared economic interest, and they will create new efficiencies in the delivery of health care. As a subsidiary benefit, the Act will encourage the enforcement agencies to revisit current enforcement guidelines, and to where appropriate grant rule of reason treatment to an expanded universe of network types.

BACKGROUND AND NEED FOR THE LEGISLATION

Health care provider networks, or "HCPNs,"—those composed of doctors, hospitals, and other entities who actually deliver health care services—are potentially vigorous competitors in the health care market. Their formation leads to lower health care costs and higher quality of care. Costs are lower because contracting directly with health care providers eliminates an intermediate layer of overhead and profit. Quality is higher because providers, and particularly physicians, have direct control over medical decision-making. Physicians and other health care professionals are better qualified than insurers to strike the proper balance between conserving costs and meeting the needs of the patient.

Concern has been raised, however, that the application of current antitrust enforcement guidelines is discouraging providers from forming networks which would have a positive effect on competition. These networks would most likely be found legal under the antitrust laws, but physicians—who are understandably concerned about potential treble damage liability—are unwilling to create them in the absence of pre-conduct approval from the enforcement agencies. H.R. 2925 removes this artificial barrier to entry, by conforming agency enforcement practices to the manner in which courts have interpreted and applied antitrust law.

A. Applicable antitrust law

Antitrust law prohibits agreements among competitors that fix prices or allocate markets. Such agreements are per se illegal. Where competitors economically integrate in a joint venture, however, agreements on prices or other terms of competition that are reasonably necessary to accomplish to pro-competitive benefits of the integration are not unlawful. *See, e.g., Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.,* 441 U.S. 1, 19–20 (1979). Price setting conduct by these joint ventures is evaluated under the "rule of reason," that is, on the basis of its reasonableness, taking into account all relevant factors affecting competition.

The antitrust laws treat individual physicians as separate competitors. Thus, networks composed of physicians which set prices for their services as a group will be considered *per se* illegal under the antitrust laws if they are not economically integrated joint ventures. In the typical provider network, competing physicians relinquish some of their independence to permit the venture to win the business of health care purchasers, such as large employers. These networks promise to provide services to plan subscribers at reduced rates. The ventures also achieve another central goal of health care reform: careful, common sense controls on the provision of unnecessary care.

However, agreements among physicians who retain a great deal of independence but set fees for their services as part of a network bear a striking resemblance to horizontal price fixing agreements. These are the most disfavored and most quickly condemned restraints in antitrust jurisprudence. The key factual question which would distinguish a network that is *per se* unlawful from one which, upon consideration of the circumstances, is acceptable because it is not anticompetitive in nature, is the degree of integration of the individuals who form the network.

While the antitrust laws provide substantial latitude in the context of collaboration among health care professionals, there is an understandable degree of uncertainty associated with their enforcement. Because each network involves unique facts—differences not only in the structure of the network, but also in the market in which it will compete—the ability of providers to prospectively determine whether their arrangement will be considered legal is limited.

B. Current enforcement standards

In order to eliminate this uncertainty, and to encourage pro-competitive behavior that would otherwise be chilled, the Department of Justice and Federal Trade Commission have established a mechanism for prospective review of proposed networks. In 1993, the antitrust enforcement agencies jointly issued "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust." These guidelines, which were amended in 1994, contain safety zones which describe provider network joint ventures that will not be challenged by the agencies under the antitrust laws, along with principles for analysis of joint ventures that fall outside the safety zones. A group of providers wishing to embark on a joint venture may request an advisory opinion from the agencies. The agencies, after reviewing the particulars of the proposed venture, then determine whether the network would fall within a safety zone, or otherwise not be challenged under the antitrust laws.

The problem is that these enforcement guidelines articulate standards that are more restrictive than the realities of the agencies' enforcement practices and the current state of the law. They treat as *per se* illegal many more networks than the antitrust laws would require, because case law does not single out integration exhibited by the sharing of financial risk as carrying special weight.

The guidelines promise rule of reason treatment to ventures where the competitors involved are "sufficiently integrated through

the network." 1994 Guidelines at 90. This is consistent with judicial interpretations of the law. *See, e.g., Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.,* 441 U.S. 1, 19–20 (1979). In fact, the guidelines state that:

> Physician network joint ventures will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies.

1994 Guidelines at 71 (emphasis added). It is the Agencies' reliance (or lack thereof) on the second prong of this statement—relating to joint ventures offering new products—which leads to a divergence from current antitrust jurisprudence.

Aside from the clause quoted above, the guidelines contain no reference to the availability of rule of reason consideration to joint ventures which offer new products producing substantial efficiencies. This is true despite the fact that case law places joint ventures on an equal footing with the sharing of financial risk as describing conduct eligible for rule of reason consideration. *See, e.g., Arizona* v. *Maricopa County Medical Society et al.,* 457 U.S. 332 (1982). Thus, while appearing to accept the idea that something other than the sharing of substantial financial risk might result in an integrated venture entitled to rule of reason analysis, in reality the enforcement of the guidelines have limited a showing of integration to the sharing of "substantial financial risk." A network which integrates in any other way—regardless of the extent of that integration, or whether a court interpreting the antitrust laws would find it to be integrated—would not likely be treated as a legitimate joint venture under the guidelines. This means that the agencies would not proceed to examine the specific facts of these joint ventures to determine their likely impact on competition; the arrangement would be viewed as *per se* illegal.

This restrictive notion of what constitutes a legitimate joint venture discourages pro-competitive ventures from entering the health care marketplace, under the guise of antitrust enforcement. It excludes potential provider networks which would mean an expanded set of consumer choices and increased competition (and thereby, lower costs) for health care services.

C. Scope of H.R. 2925

H.R. 2925 overcomes this barrier by requiring that the conduct of an organization meeting the criteria of a Health Care Provider Network be judged under the rule of reason. The result will be to permit a case-by-case determination as to whether the conduct of that HCPN would be pro-competitive, and thus permissible under the antitrust laws. It is important to emphasize, however, that this is not an exemption from the antitrust laws. In no event would providers be allowed to set prices or control markets if, in doing so, they have an anticompetitive effect on the market. The normal principles of antitrust law will continue to apply. There could just be no automatic assumption that such networks would be *per se* illegal.

Only an organization meeting specified criteria would qualify for the more liberal, rule of reason consideration. The network must have in place written programs for quality assurance, utilization review, coordination of care and resolution of patient grievances and complaints. It must contract as a group, and mandate that all providers forming part of the group be accountable for provision of the services for which the organization has contracted. If these criteria are not met, the entity could still be considered per se illegal.

Rule of reason consideration would be extended not only to the actual performance of a contract to provide health care services, but also to the exchange of information necessary to establish a HCPN. An important limitation on the exchange of information is that it must be reasonably required in order to create a HCPN. Further, information obtained in that context may not be used for any other purpose.

H.R. 2925 delegates to the Department of Justice and the Federal Trade Commission authority to specify how rule of reason consideration would be implemented under these circumstances.

The Committee is particularly aware of the increased certainty gained by implementing this standard through legislation rather than enforcement guidelines. The "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust" are just that—policy and principles. They lack permanence because they are always subject to possible change by the Agencies themselves. They have no binding effect on private parties. Thus, costly and time-consuming private treble damage actions could still be filed in court against well-intentioned networks that have met a test established by guidelines. And most importantly, the guidelines are not binding on any court.

H.R. 2925 is a measured approach to the antitrust issues presented by the growth and evolution of the health care delivery market. It does not exempt any conduct from scrutiny under the antitrust laws. It does, however, ensure that legitimate joint ventures will have the opportunity they deserve to show that their restrictive practice does not impose an unreasonable restraint on competition. *See, e.g., Chicago Board of Trade* v. *United States,* 246 U.S. 231, 238 (1918).

HEARINGS

The Full Committee held two days of hearings on H.R. 2925. Testimony on the bill was received from Robert Pitofsky, Chairman of the Federal Trade Commission, on February 27, 1996, and on February 28, 1996 from a panel including Nancy Dickey, M.D., on behalf of the American Medical Association; Gayle McKay, on behalf of the American Association of Nurse Anesthetists; Margaret Metzger, Senior Vice President and Corporate General Counsel, Tufts Associated Health Plan, on behalf of the Group Health Association of America/American Managed Care and Review Association; and Professor Clark C. Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law.

COMMITTEE CONSIDERATION

On March 12, 1996, the Committee met in open session and ordered favorably reported the bill H.R. 2925 without amendment by a recorded vote of 20 to 4, a quorum being present.

VOTE OF THE COMMITTEE

1. Mr. Conyers offered an amendment to limit coverage of the Act to Federal antitrust law. The amendment was defeated by a vote of 7 to 17.

AYES	NAYS
Mr. Conyers	Mr. Hyde
Mrs. Schroeder	Mr. Moorhead
Mr. Nadler	Mr. Gekas
Mr. Scott	Mr. Coble
Mr. Watt	Mr. Smith (TX)
Ms. Lofgren	Mr. Schiff
Ms. Jackson Lee	Mr. Canady
	Mr. Goodlatte
	Mr. Buyer
	Mr. Bono
	Mr. Heineman
	Mr. Chabot
	Mr. Flanagan
	Mr. Barr
	Mr. Frank
	Mr. Boucher
	Mr. Reed

2. The Committee voted, by recorded vote of 20 to 4, to favorably report the bill without amendment.

AYES	NAYS
Mr. Hyde	Mr. Conyers
Mr. Moorhead	Mrs. Schroeder
Mr. Gekas	Mr. Nadler
Mr. Coble	Mr. Scott
Mr. Smith (TX)	
Mr. Schiff	
Mr. Canady	
Mr. Goodlatte	
Mr. Buyer	
Mr. Bono	
Mr. Heineman	
Mr. Chabot	
Mr. Flanagan	
Mr. Barr	
Mr. Frank	
Mr. Boucher	
Mr. Reed	
Mr. Watt	
Ms. Lofgren	
Ms. Jackson Lee	

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee reports that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT FINDINGS

No findings or recommendations of the Committee on Government Reform and Oversight were received as referred to in clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives.

NEW BUGET AUTHORITY AND TAX EXPENDITURES

Clause 2(l)(3)(B) of House Rule XI is inapplicable because this legislation does not provide new budgetary authority or increased tax expenditures.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

In compliance with clause 2(l)(C)(3) of rule XI of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R. 2925, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 22, 1996.

Hon. HENRY J. HYDE,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed federal and intergovernmental cost estimates for H.R. 2925, the Antitrust Health Care Advancement Act of 1996. The bill would impose a mandate on state governments (see the enclosed intergovernmental mandate statement).

Enacting H.R. 2925 would affect direct spending and receipts. Therefore, pay-as-you-go procedures would apply to this bill. However, CBO cannot estimate the amount by which the federal outlays and receipts would be changed.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, Director).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2925.

2. Bill title: Antitrust Health Care Advancement Act of 1996.

3. Bill status: As ordered reported by the House Committee on the Judiciary on March 12, 1996.

4. Bill purpose: This bill would require provider sponsored networks (PSNs) to be judged on a case-by-case basis as to whether the conduct of such groups is permissible under antitrust laws. PSNs are groups composed of physicians, nurses, hospitals and other entities who deliver health care services. Under current law, physicians are treated as separate competitors, making most of their joint ventures automatically a violation of antitrust laws. This bill also would require the Department of Justice (DOJ) and the Federal Trade Commission (FTC) to establish guidelines for evaluating the legality of PSNs.

5. Estimated cost to the Federal Government:

Spending subject to appropriations.—Based on information from DOJ and the FTC, CBO believes that enacting this bill would raise the burden of proof required for the enforcement and prosecution of certain cases involving PSNs. Consequently, additional legal and investigatory resources could be needed. Based on information from DOJ, CBO estimates that this type of antitrust activity would impose an average cost of about $250,000 per case. A typical case could extend over several years. It is very difficult to project the extent to which enacting this bill would result in the formation of PSNs nationwide and to what extent newly formed networks would require substantial investigation and ultimately prosecution by the federal government. Given the uncertainty with how the medical community and marketplace would respond to the provisions under this bill, DOJ and the FTC have no basis for predicting future caseload. If relatively few cases are investigated, the resultant costs to the federal government would be less than $1 million each year. If, on the other hand, caseload were to increase significantly, we estimate that annual costs could total between $3 million and $5 million. Any such increase in costs to the federal government would be subject to appropriations of the necessary funds.

As explained below, the bill also would increase discretionary spending for federal employees' health benefits, but CBO cannot estimate the extent of that increase at this time.

Direct spending and revenues.—By loosening the antitrust restrictions on the establishment of provider sponsored networks, H.R. 2925 would affect competition in the market for health care and could affect the federal budget. On the one hand, this provision would encourage the formation of PSNs, potentially adding health plans to the market and enhancing competition. On the other hand, H.R. 2925 would effectively cause the enforcement of antitrust violations by health care providers to be relaxed. Health providers seeking to prevent managed care networks from gaining strength in certain areas could use the exemption to share financial data and develop strategies to resist network formation and competition. On balance, CBO estimates that health costs would increase, raising the costs of government programs and reducing revenues, but cannot estimate the magnitude of the impact.

The bill could affect federal outlays for Medicare by relaxing antitrust enforcement and giving a competitive edge to provider sponsored health networks. States may begin to license PSNs, and Medicare would be likely to accept risk contracts with licensed PSNs that apply. This could exacerbate risk selection problems in Medicare because doctors in provider sponsored networks would be

especially able to steer their healthy patients to the network and advise their sick patients to remain in the traditional fee-for-service plan. Any competitive forces spawned by the formation of additional PSNs would not lower Medicare costs because Medicare pays all such plans based on costs in the fee-for-service program.

Higher health costs would affect federal outlays for federal employees' health benefits. Federal outlays are a proportion of total premiums for federal workers, and premiums would increase as health costs rose. The increase would affect both mandatory and discretionary outlays.

Revenues would also fall as premiums for employment-based insurance rose in response to higher health costs. Higher premiums would trigger reactions by nonfederal employers, so that health benefits and coverage, other fringe benefits, and cash wages would be reduced. To the extent that cash wages were reduced, federal income and payroll tax revenues would fall.

The costs of this bill fall within budget functions 370, 550, and 750.

6. Pay-as-you-go considerations: Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. CBO believes that H.R. 2925 would increase federal outlays and decrease tax revenues but cannot estimate the amount of these changes.

7. Estimated impact on State, local and tribal governments: The bill would impose a mandate on state governments (see attached intergovernmental mandate cost statement).

8. Estimated impact on the private sector: The bill contains no private sector mandates as defined in Public Law 104–4.

9. Previous CBO estimate: None.

10. Estimate prepared by: Federal Cost Estimate: Susanne S. Mehlman for justice programs; Jeffrey Lemieux for health programs. Private Sector Impact: Bruce Vavrichek.

11. Estimate approved by: Robert A. Sunshine (for Paul N. Van de Water, Assistant Director for Budget Analysis).

CONGRESSIONAL BUDGET OFFICE—ESTIMATED COST OF INTERGOVERNMENTAL MANDATES

1. Bill number: H.R. 2925.

2. Bill title: Antitrust Health Care Advancement Act of 1996.

3. Bill status: As ordered reported by the House Committee on the Judiciary on March 12, 1996.

4. Bill purpose: H.R. 2925 would require case-by-case determinations about whether health care provider sponsored networks (PSNs) are permissible under antitrust laws. PSNs are groups composed of physicians, nurses, hospitals, and other entities who deliver health care services. Under current state and federal antitrust laws, most such joint ventures are automatically illegal.

5. Intergovernmental mandates contained in the bill: H.R. 2925 would require that states, in enforcing their antitrust laws, judge PSNs on a case-by-case basis rather than ruling them illegal per se.

6. Estimated direct costs to State, local, and tribal governments:

(a) *Is the $50 Million Annual Threshold Exceeded?* No.

(b) *Total Direct Costs of Mandates:* CBO estimates that the mandate in H.R. 2925 would result in aggregate direct costs to state governments of $5 million to $15 million per year. The mandate would not directly affect local or tribal governments.

(c) *Estimate of Necessary Budget Authority:* Not applicable.

7. Basis of estimate: Based on information from federal and state antitrust officials, CBO expects that H.R. 2925 would raise the burden of proof required to enforce and prosecute certain cases involving PSNs. State antitrust enforcement divisions would need to retain economists and health care experts to a greater degree than under current law as well as spend more time researching and prosecuting the PSN cases they pursue. Based on information from antitrust experts, CBO estimates that the cost of prosecuting cases under this higher standard would average about $250,000 per case—as much as 10 times the amount currently spent investigating and prosecuting a typical PSN case. A typical case could extend over several years.

According to the National Association of Attorneys General, approximately half of the states actively engage in antitrust enforcement. To maintain their current level of enforcement under the new standard, CBO estimates that these states, on average, would incur additional costs totaling about $300,000 annually. If, as many experts predict, however, H.R. 2925 results in a substantial increase in the number of PSN cases needing investigation, CBO estimates these costs could double for many states. Additional costs for all states would total between $5 million and $15 million annually.

Based on information from seven states with aggressive enforcement programs, CBO expects that many states would likely alter their caseloads to minimize these costs. They would become more selective, investigating and prosecuting fewer, but more complicated, health care antitrust cases.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None.

9. Other impacts on State, local, and tribal governments: CBO believes that private health insurance premiums would rise if H.R. 2925 were enacted. This, in turn, would have a negative budget impact on state, local, and tribal governments. Based on a survey of states and health care and antitrust experts, CBO assumes that enacting H.R. 2925 would result in less comprehensive enforcement of health care antitrust violations. While the bill's intent is to encourage PSNs to establish themselves in an efficient and competitive manner, we expect that the net effect of the legislation actually would be to increase anticompetitive behavior.

These factors would cause health costs to increase slightly, raising health insurance premiums as well as the cost of government medical assistance programs. The cost of increased premiums for covered employees of state, local, and tribal governments, however, would be primarily borne by the employees themselves and not the government employers. CBO estimates that employers providing health care coverage would decrease cash wages and fringe benefits to compensate for increased health insurance costs. Total compensation paid would, thus, remain unchanged in the long run. A decline in cash wages would also lead to a decrease in state and local government income and payroll tax receipts. At this time,

CBO is not able to quantify the magnitude of likely increases in health care costs or the subsequent budget impacts on state, local, or tribal governments.

10. Previous CBO estimate: None.

11. Estimate prepared by: Karen McVey.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that H.R. 2925 will have no significant inflationary impact on prices and costs in the national economy.

SECTION-BY-SECTION ANALYSIS

Section 1

The Act may be cited as the "Antitrust Health Care Advancement Act of 1996."

Section 2

Section 2 of the Act describes the networks and the conduct to which the rule of reason, rather than per se, standard is to be applied in antitrust cases.

Section 2(a) provides that in an action under Federal or State antitrust laws, the rule of reason standard shall be applied to certain types of conduct. First, it shall apply to the conduct of a health care provider when it shares information relating to costs, sales, profitability, marketing, prices or fees of any health care service with another health care provider. The provisions of section 2(a)(1) only apply to the extent that the exchange of this information is solely for the purpose of establishing a health care provider network, and is reasonably required for that purpose, and, to the extent that such information is not used for any other purpose.

Paragraph 2 provides that the rule of reason standard shall apply to the conduct of a health care provider network in negotiating, making or performing a contract, to the extent that contract is to provide health care services to individuals under the terms of a health benefit plan. The conduct of a health care provider who is a member of a network, and acting on its behalf, comes within the scope of this paragraph. The conduct covered by this paragraph is specifically intended to include the establishment and modification of a fee schedule, and the development of a panel of physicians.

Paragraph 3 brings within the rule of reason standard the conduct of any member of a health care provider network which is intended for the purpose of providing health care services under the contract.

Section 2(a) of the bill provides that the conduct of health care provider networks and their members shall not be deemed illegal per se, and shall be judged instead under the rule of reason mode of antitrust analysis. The Committee recognizes that the standards for rule of reason analysis evolve through court decisions. The bill is not intended to prescribe or codify any particular criteria for the

rule of reason analysis to be applied to health care provider networks. Rather, it would guarantee health care provider networks the rule of reason treatment that is accorded to joint ventures under Supreme Court precedent. See, e.g., FTC v. Indiana Federation of Dentists, 476 U.S. 447, 460 (1985). Rule of reason analysis varies depending on the nature of the challenged conduct, and the bill is not intended to curtain use in appropriate cases of an abbreviated rule of reason analysis as established by the courts.

Subsection (b) defines various terms as used in subsection (a).

"Antitrust Laws" is given the same meaning as used in subsection (a) of the first section of the Clayton Act, except that it also include the portions of section 5 of the Federal Trade Commission Act which apply to unfair methods of competition.

A "Health Benefit Plan" is defined broadly to cover both public and privately funded plans. The contractual relationship referenced in this section is intended to be that between the patient and the entity which agrees to furnish general health care services, not the contract between the health care provider network and the entity which contracts with the patient for provision of health care services.

The term "Health Care Provider" includes any individual or entity that is engaged in the delivery of health care services and that is required by State law or regulation to be licensed or certified by the State to provide those services.

A "Health Care Service" is one for which payment may be made under a health benefit plan.

Paragraph 5 defines a "Health Care Provider Network" as an organization which exhibits seven specified traits. The Committee believes that, under current antitrust jurisprudence, an organization which meets this criteria would be deemed by a court to constitute a legitimate joint venture, and would therefore be granted rule of reason analysis. The Act merely codifies this result.

The requirement in subparagraph 5(B) that the organization be funded in part by capital contributions made by the members of the organization is not intended as an indicia of the sharing of financial risk. The Committee recognizes that it is a matter of fact under each particular circumstance whether any particular amount of capital contribution in fact gives the members of the organization an incentive to behave pro-competitively. This requirement was added to distinguish members of the organization from other health care providers who might provide services through the health care provider network, but in the capacity of employees or contractors rather than members of the organization.

Subparagraph 5(C) is intended to ensure that the network, rather than its individual members, is in fact the entity which has the obligation, and which receives compensation, for the health services provided.

The programs required to be established under subparagraphs 5 (D), (E), and (F) must cover all health care providers within the health care provider network, and all patients being served by the network. The Committee did not intend to extend an obligation to the network to create programs which would apply to services provided by other health care providers or to patients participating in a health benefit plan which are never served through the network.

The definition of "State" contained in subparagraph (6) incorporates by reference the meaning given the term in section 4G(2) of the Clayton Act.

Section 3

Section 3 of the Act provides that within 180 days of enactment, the Attorney General and the Federal Trade Commission shall issue joint guidelines as to the application of the Act. These guidelines are intended to be as factually specific as possible, so as to provide certainty to the regulated community as to whether particular conduct is likely to violate the antitrust laws. The Committee expects that the Department of Justice and the Federal Trade Commission will provide advisory opinions to interested parties, based on the guidelines requires to be promulgated under this section.

DISSENTING VIEWS

We strongly oppose H.R. 2925, which would exempt medical provider groups responsible for price fixing and other anticompetitive activities from antitrust liability under the "per se" rule of antitrust law.[1] The legislation removes the most effective deterrent to anti-competitive conduct in the health care market and poses grave risks to health care consumers.

The Congressional Budget Office predicts that under the legislation, "health care costs would increase, raising the costs of government programs [and] giving a competitive edge to provider sponsored health networks."[2] CBO also anticipates that as a result of the increased anti-competitive conduct under H.R. 2925 there will be a reduction in federal revenue:

> Revenues would * * * fall as premiums for employment-based insurance rose in response to higher health costs. Higher premiums would trigger reactions by nonfederal employers, so that health benefits and coverage, other fringe benefits, and cash wages would be reduced. To the extent that cash wages were reduced, federal income and payroll revenues would fall.[3]

The legislation is an unnecessary reaction to the contention by some physicians and other medical providers that the nation's antitrust laws impede their ability to band together to compete against HMOs, Preferred Provider Organizations (PPOs), and other managed care organizations. This Congress has already criticized as being all too willing to bend to special interests, and we should not alter the antitrust laws at the further expense of consumers. Indeed, this specific provision has been criticized by the *New York Times* as constituting part of a package of legislative "bribes for doctors."[4]

I. CURRENT LAW IS NOT AN UNNECESSARY IMPEDIMENT TO THE DEVELOPMENT OF MEDICAL PROVIDER GROUPS

An examination of current law indicates that collective activity among physicians already benefits from a number of antitrust doctrines and practices. Under the antitrust laws, any joint venture among competitors who "economically integrate" is subject to anti-

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[1] The legislation applies so long as the medical provider groups exhibit certain characteristics, such as partial funding by members of the network, common contract administration, and review of quality and effectiveness of treatment.

[2] Congressional Budget Office Letter to Hon. Henry Hyde, Chairman, Comm. on the Judiciary (May 22, 1996) [hereinafter "CBO Letter"].

[3] Id.

[4] New York Times, October 15, 1995 at Section 4, page 14 ("the danger with [the Republican antitrust proposal] is that it invites doctors to engage in blatantly anticompetitive behavior. [Gingrich] would allow doctors who have no intention of going into business together to conspire among themselves to impose high fees and needlessly expensive treatment practices on health plans using their services.")

trust scrutiny only under the more lenient "rule of reason."[5] In addition, the Department of Justice and FTC have promulgated health care guidelines specifying that the "rule of reason" applies to any joint venture activity involving physicians and other medical providers who share "substantial financial risk" or create a new product producing "substantial efficiencies."[6] (The rationale behind the court-made rules and special guidelines is that risk sharing encourages providers to act together to provide genuine efficiencies which can benefit consumers, in contrast to naked cartels which merely seek to raise prices.)

To the extent there is any residual uncertainty regarding the antitrust liability of physician groups, they are permitted to submit their proposed business plans for expedited pre-clearance review by the enforcement agencies. Moreover, the DOJ and FTC have committed to work with the medical community and other affected parties on an ongoing basis to adapt their health care guidelines to conform to changing market conditions. At the hearing on this issue, FTC Chairman Pitofsky estimated that the most recent review would be completed by August of 1996 at the latest.[7]

As a result of the aforementioned rules and procedures, the nation has seen an explosion in the development of physician-operated health care networks in recent years. Since 1991, the FTC and DOJ have approved 31 of the 34 proposed provider network plans presented to them, hundreds of additional physician networks have been formed under the agencies' health care guidelines, and many more are in the development stage.[8] Studies have shown that a full 15% of HMOs and 20% of PPOs are provider-owned and more than 9 million people are enrolled in provider-owned PPOs.[9]

II. H.R. 2925 PROVIDES AN UNJUSTIFIED SPECIAL INTEREST EXCEPTION TO OUR ANTITRUST LAWS

During the House Judiciary Committee's hearing on H.R. 2925, four out of the five witnesses that testified stated unequivocally that there was no compelling justification to amend the antitrust laws to provide special preference to physicians. A broad and diverse coalition of antitrust officials and professionals;[10] consumer

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[5] See, e.g., *Broadcast Music, Inc.* v. *Columbia Broadcasting System,* 441 U.S. 1 (1979). The "per se" rule applies automatically to ban price fixing and other blatantly anticompetitive activities, while the more lenient "rule of reason" considers the overall pro- or anti-competitive nature of the conduct.

[6] U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to the Health Care and Antitrust (4 Trade Reg. Rep. (CCH) Par. 13,152, at 20,791–92).

[7] Health Care Reform Issues, Antitrust, Medical Malpractice, and Volunteer Liability: Hearing Before the Comm. on the Judiciary, U.S. House of Representatives, 104th Cong., 2d Sess., February 27–28, 1996 [hereinafter "1996 Hearings"], Prepared Statement of Robert Pitofsky, Chairman, Federal Trade Commission at 22. *See also* Letter from Robert Pitofsky, Chairman, Federal Trade Commission, to Hon. Henry J. Hyde, Chairman, Comm. on the Judiciary (April 8, 1996) ("I am pleased to report that the project is on schedule and indeed we may be able to even beat the timetable that I discussed in my testimony last month"). The Administration has also endorsed the approach of allowing the antitrust enforcement agencies to revise their guidelines to respond to industry concerns rather than through altering the antitrust statutes. See Letter from Alice M. Rivlin, Director Office of Management and Budget, to Hon. John Conyers, Jr. (April 25, 1996).

[8] *See* 1996 Hearings *supra* note 7, Prepared Statement of Robert Pitofsky at 10.

[9] Id.

[10] See Letters from:

Continued

groups;[11] and employers, health professionals, hospital systems, physicians group practices, network based delivery systems and health plans[12] all oppose the bill as being an unnecessary and costly special interest exemption from the antitrust laws.

Eliminating potential liability for antitrust violations under the "per se" rule ignores the fact that the rule provides a bright line against blatantly anticompetitive conduct and avoids expensive and protracted litigation. CBO estimates that "rule of reason" cases cost an average of $250,000 per case, or 10 times the cost of a typical "per se" case.[13] As recently as 1991, the FTC used the "per se" rule to halt a physician boycott aimed at preventing the Cleveland Clinic from establishing a high quality practice in Florida.[14] And in 1988, a successful "per se" action was brought against a group of physicians engaged in a group boycott against competing nurse anesthetists.[15] Nurses-midwives have experienced similar boycotts.[16]

H.R. 2925 has also been justifiably criticized by the Department of Justice and FTC as being unnecessarily rigid and for failing to require any substantial risk sharing or the creation of any economic efficiencies.[17] Chairman Pitofsky has noted that characteristics required by the bill to receive "rule of reason" treatment are not adequate to differentiate between joint ventures offering genuine efficiencies from those seeking to fix prices and impede competition.[18] Moreover, the Majority's own witness, Duke Professor Clark C. Havighurst, acknowledged that the bill "would overregulate physician networks—even more than they are overregulated under the current enforcement guidelines [and] would not protect many phy-

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(i) Anne Bingaman, Assistant Attorney General, U.S. Department of Justice and Robert Pitofsky, Chairman, Federal Trade Commission to Hon. Pete Stark, Member of Congress (October 10, 1995);

(ii) Antitrust Committee and Health Care Task Force of the National Associations of Attorneys General to Hon. Newt Gingrich, Speaker of the House (October 26, 1995); and

(iii) John DeQ. Briggs, Chair, Section of Antitrust Law, American Bar Association to Hon. John Conyers, Jr., Ranking Member, Comm. on the Judiciary (February 26, 1996).

[11] See Letter from Consumer Federation of America to Hon. Henry Hyde, Chairman, Comm. on the Judiciary (February 27, 1996).

[12] *See* Letters from:

(i) American Optometric Association to Hon. Henry Hyde, Chairman, Comm. on the Judiciary (March 8, 1996); and

(ii) American Chiropractic Association, American Association of Nurse Anesthetists, American Federation of Home Health Agencies, American Occupational Therapy Association, Association of Private Pension and Welfare Plans, Aetna, Cigna, HealthCare COMPARE, Corp., Health Insurance Association of America, Northwestern National Life, Opticians Associations of America, The Principal Financial Group, U.S. Healthcare, Inc., American Group Practice Association, American College of Nurse-Midwives, AmHS/Premier/SunHealth, American Optometric Association, American Association of Health Plans, Blue Cross and Blue Shield Association, Deer & Co., Healthcare Leadership Council, Independence Blue Cross, Pan American Life, The Prudential, United Health Care, Wausau Insurance Companies to Members, U.S. House of Representatives, Comm. on the Judiciary (March 11, 1996).

[13] CBO letter, *supra* note 2.

[14] Medical Staff of Broward General Medical Center, 114 F.T.C. 542 (1991) (consent order).

[15] See *Oltz* v. *St. Peter's Community Hospital,* 861 F.2d 1440 (5th Cir. 1988).

[16] See Medical staff of Memorial Hospital Center, 5 Trade Reg. Rep. Par. 22,508 (January 28, 1988); *See also Nurse–Midwifery Association* v. *Hibbit,* 918 F.2d 605 (6th Cir. 1990).

[17] Letter from Anne Bingaman, Assistant Attorney General, U.S. Department of Justice and Robert Pitofsky, Chairman, Federal Trade Commission to Hon. Pete Stark, Member of Congress (October 10, 1995) (legislation is "unnecessary to protect any legitimate activity [and] would immunize a broad range of anticompetitive activities that could harm consumers and raise health care costs").

[18] For example, the presence of characteristics such as credential review programs referenced in the legislation have been present in networks that merely served as vehicles to increase prices. See 1996 Hearings *supra* note 7, prepared statement of Robert Pitofsky at 18.

sician networks that equally deserve consideration under the rule of reason." [19]

Another problem with the legislation is its failure to preserve traditional state antitrust prerogatives in the health care enforcement area.[20] CBO has certified that provisions in the legislation preempting state antitrust laws constitute an unfunded mandate which would "double" state antitrust enforcement costs. CBO also believes that the state law preemption provisions "would result in less comprehensive enforcement of health care antitrust violations" by the states.[21] Republicans claim to have run on a platform of returning power to the States, but all too often in this Congress they have been willing to say that the federal government knows best when it comes to protecting the special interests.

In the one hundred years of the development of the antitrust laws, no industry has received a specific exemption from prosecution from "per se" antitrust liability for price fixing activity.[22] To the extent there is any perceived problem that the antitrust laws unnecessarily impede development of physician groups, the enforcement agencies are fully capable of addressing the matter through guidelines. We urge opposition to this unneeded exemption.

JOHN CONYERS, Jr.
ROBERT C. SCOTT.
PATRICIA SCHROEDER.
HOWARD L. BERMAN.

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[19] *See* Letter from Clark C. Havighurst, Professor, Duke University School of Law, to Hon. Henry J. Hyde, Chairman, Comm. on the Judiciary (March 8, 1996).

[20] An amendment offered by Mr. Conyers to eliminate the provision in H.R. 2925 preempting state antitrust laws failed by a vote of 7 to 17.

[21] CBO letter, *supra* note 2.

[22] The National Cooperative Research and Production Act of 1993 (15 U.S.C. 4301–06), often cited by proponents as precedent for H.R. 2925, specifically *excludes* marketing and price activities from its coverage. Mandating that "rule of reason" be applied to price fixing agreements, as H.R. 2925 does, would be unprecedented.